# EMERGENCY PSYCHIATRY

ASSESSMENT AND MANAGEMENT OF AGGRESSIVE PATIENT

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- Aggression and violence may be a manifestation of underlying psychiatric disorders/or due to a medical disorder .
- Some patients try to use aggression as means of achieving a particular goal, such as being seen earlier or obtaining drugs.

# HOW TO RECOGNISE AGGRESSION

| Physical Changes | Behavioral Changes |
| --- | --- |
| Sweating | Loud speech or shouting |
| Clenched teeth and jaws | Pointing with the finger |
| Shaking | Swearing/verbal abuse |
| Muscle tension | Over-sensitivity to what is said |
| Clenched fists | Standing too close |
| Rapid breathing | Aggressive posture |
| Staring eyes | Tone of voice |
| Restlessness, fidgeting | Problems with concentration |
| Flushed face or extreme paleness of face | Stamping feet, Banging/kicking things |
| Rise in pitch of voice | Walking away |

# ALWAYS REMEMBER

- Safety to self and others comes 1st
- Ideally the assessment area should have no dangerous objects easily at hand .
- should have more than one exit.

# MANAGING AN ACUTE EPISODE

- Before treating the behavioral disturbance consider what maybe causing it.

# COMMON CLUES THAT A PSYCHIATRIC CAUSE IS LIKELY INCLUDE :

- past history of mental illness, drug use or alcoholism .
- Current medications, general physical appearance including self-care,
- appropriateness of mood and engagement, manner and content of speech, posture and movement.
- Wherever possible collateral history should be sought from family, friends and healthcare providers.

# *MNEMONIC FOR CAUSES OF ABNORMAL / AGITATED BEHAVIOUR

- **Metabolic:** Renal / liver failure; electrolyte abnormalities; abnormal glucose;
- **Oxygen:** Hypoxaemia
- **Vascular:** Stroke, sub-arachnoid bleed or vasculitis
- **Endocrine:** Abnormal thyroid hormones; abnormal cortisol
- **Seizures:** Post-ictal state
- **Trauma:** Concussion; sub-dural or extra-dural bleed
- **Uraemia:** Renal failure
- **Psychiatric:** Primary psychiatric disorder
- **Infections**: Pulmonary, urinary, cellulitis, meningitis, sinusitis, cholecystitis, osteitis
- **Drugs:** Alcohol withdrawal, recreational, non-adherence to psychiatric treatment

1- assess circumstances leading to the offence :

- Location, people, timing, triggers, substances involved , severity .

2-Assess patient's view of the offence :

- Anger, denial, lack of guilt, ongoing violence thoughts.

3-Obtain psychiatric history :

- Psychotic disorders, mood disorders ( manic symptoms ) , substance abuse, low IQ .

4-Obtain past psychiatric and forensic history :

- Past history of violence, arrests .

## 5-Obtain significant personal history :

- Traumatic childhood, violent father, victim of domestic violence .

## 6- look for other risk factors :

- Single, unemployed, drugs & alcohol.

## 7-Personality traits:

- Repeated impulsive behavior, difficulty in coping with stress, antisocial personality traits.

- A general physical examination including neurological examination looking for higher function and orientation.
- Measure the vital signs and if possible, oxygen saturation and blood glucose.
- Initial basic blood tests such as a full blood count, chemistry, blood sugar, liver and renal function are appropriate if results can be quickly obtained.
- Further tests including blood alcohol level, urine drug screen, urinalysis and culture
- cerebral CT scanning may be required if the patient is hospitalised.

# NON-PHARMACOLOGICAL MANAGEMENT

# DE-ESCALATION

- Use an empathic non-confrontational approach, but set boundaries.
- **Listen** to the patient, but avoid giving opinions on issues .
- Offer food, drink and a place to sit.
- Avoid excessive stimulation.
- Avoid aggressive postures and prolonged eye contact.
- Recruit family, friends, case managers to help.
- Address medical issues especially pain and discomfort.
- Try to ascertain what the patient actually wants and the level of urgency

# SECLUSION

*Seclusion* involves the placement of a patient alone in a locked room from which s/he can't freely exit.

This measure is used frequently after an aggressive outburst

Decisions for seclusion:

- Containment of individual.
- Isolation.
- To reduce sensory stimuli.

# RESTRAIN

- *Restrain* has the intent to control an aggressive patient whilst restore the safety of the others.
- It should be implemented as the last resort, when other options have failed.
- this method could be traumatic for the patient and staff, effecting the therapeutic relationship as it can be perceived as punishment for their actions.

# PHARMACOLOGICAL MANAGEMENT

| Drug | Usual adult dose | Adverse events and management |
|---|---|---|
| Diazepam | 5–10 mg oral or intravenously. Max 30 mg per event. Longer acting than midazolam. | • Oversedation – maintain airway, coma position, provide oxygen.<br>• Hypotension – lay down, intravenous fluids .<br>• Airway or respiratory compromise – support airway, give oxygen.<br>• Parodoxical reactions |
| Lorazepam | 2 mg. Max 10 mg in 24 hours. | |
| Midazolam | 5–10 mg intramuscularly. Max 20 mg per event. Rapid onset. | |
| Olanzapine | 5–10 mg oral. Max 30 mg per event. | • Hypotension – lay down, intravenous fluids<br>• Seizure – coma position, clear airway, benzodiazepines |
| Haloperidol | 5–10 mg intramuscularly. Max 20 mg per event. | • Acute dystonia – benztropine 2 mg oral or intramuscularly or intravenously<br>• Hypotension – lay down, intravenous fluids |

# POST-SEDATION MANAGEMENT

- the patient will need to be transferred for further medical and then psychiatric assessment as soon as possible.

- closely observed and monitored.

# THANK YOU